

HEALTH CARE ACQUIRED CONDITIONS
OTHER PROVIDER PREVENTABLE CONDITIONS
REPORTING TOOL

AMPM POLICY 920, EXHIBIT 920-1 HEALTH CARE ACQUIRED CONDITIONS OTHER PROVIDER PREVENTABLE CONDITIONS REPORTING TOOL

| DATE SUBMITTED: | YEAR: | QUARTER: | CONTRACTOR NAME: | |
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| LAST NAME | FIRST NAME | AHCCCS ID | DATE OF BIRTH MM/DD/YYYY | DATE OF INCIDENT OR SERVICE MM/DD/YYYY | HOSPITAL OR SETTING (USE PROPER NAME OF PROVIDER) | НСАС | ОРРС | WAS THERE A QUALITY OF CARE CONCERN? | SEVERITY LEVEL |
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